1

15835

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15859

1. DECEASED-NAME (Type or print) First: Clara Middle: Lost: Anderson	2a. DATE OF DEATH Month: Oct. Day: 28 Year: 1970	2b. HOUR: 9:58 P.M.	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Aug. 17 1889	6. AGE (In years lost birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Household	12b. KIND OF BUSINESS OR INDUSTRY: Household
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Somerset	13c. CITY OR TOWN: Deal Island	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: Main Road
14. FATHER'S NAME First: William Middle: T Lost: Dashiell	15. MOTHER'S MAIDEN NAME First: Amelia Middle: Lost: Riggin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: Unknown	17. INFORMANT Address: T Howard Anderson-Deal Island, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4339

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchopneumonia	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Cerebral thrombosis	2 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (X) (this hospital) attended the deceased from 9/22, 19 70, to 10/28, 19 70, that (X) (we) last saw the deceased alive on 10/28 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L V Maldve, M D DEGREE	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 10/29/70
22d. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury, Md.	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/31/70	23c. NAME OF CEMETERY OR CREMATORY: ST JOHNS CEMETERY	23d. LOCATION (City or Town) (County) (State): DEAL ISLAND SOM MD
24. FUNERAL DIRECTOR: Leroy Webster	ADDRESS: PRINCESS ANNE MD	25a. REC'D BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon O. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1-69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15860

1. DECEASED-NAME (Type or Print) First: IDORA (TEX)	Middle:	Last: BAKER	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: 10 Day: 15 Year: 70	2b. HOUR: 7:20 P.M.					
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 6-13-1928	6. AGE (In years last birthday): 42 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month 10 Day 15 Year 1970	2d. HOUR: M				
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.						
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY: National Freight						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Mt. Hermon Rd.,					
14. FATHER'S NAME First: Harry	Middle:	Last: Baker	15. MOTHER'S MAIDEN NAME First: Mary	Middle:	Last: Cook				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WWII	16b. SOCIAL SECURITY NO.: 215-20-2611	17. INFORMANT: Mrs. Syliva Marine Baker	ADDRESS: see sec 13					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Shotgun wound of heart — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 7 10-15-70	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
		Self-inflicted.

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	own home	Mt. Hermon Rd.,	Salisbury,	Wico.,	Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Oct. 16, 1970

EXAMINER'S NAME (Type): Dr Earl L. Royer ADDRESS (Street, city, town, or county): Camden Ave., Salisbury, Maryland Wicomico

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-18-1970	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home	Salisbury, Maryland	OCT 20 1970	Bertie D. Rogers

VR 415ME (5) 50M-REV 1/68

15837

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15861

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print): Rollie R. Baker (First: Rollie; Middle: R.; Last: Baker)
2a. DATE OF DEATH: Month Oct Day 11 Year 1970
2b. HOUR: M
3. SEX: M
4. RACE: W
5. DATE OF BIRTH: Sept. 18, 1901
6. AGE (In years last birthday): 69 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Fert. Rep.
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Wor
13c. CITY OR TOWN: Showell
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: —
14. FATHER'S NAME: First Sewell Middle Baker Last
15. MOTHER'S MAIDEN NAME: First Lillie Middle Hudson Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service): No
16b. SOCIAL SECURITY NO.: 215-07-9044
17. INFORMANT: Mrs. Rollie R. Baker Address: Showell Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 wks.
4339
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yes.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9/28, 1970, to 10/11, 1970 that (I) (we) last saw the deceased alive on 10/10 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we) (did)~~ (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/12/70
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/15/70
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Evergreen
23d. LOCATION (City or Town) (County) (State): Berlin Wor Md
24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md.
25a. REC'D BY REGISTRAR: DATE OCT 16 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) 45M - 1/69

(5)

15838

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#5,6,FilmG430 11/5/70 kam

CERTIFICATE OF DEATH

15862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
CHARLES	W.	Banks	10	16	70	1 15 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	WHITE	May 17, 1921	49 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PA.	USA		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	MAGISTRATE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
DEL.	SUSSEX	DAGSBORO	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
VICTOR	S.	BANKS	ELIZABETH		BANKS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
YES	WW II	213-03-0422	MARGARET S. BANKS,	DAGSBORO, DEL.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2509

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Nephritis — years

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	Yes

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-2-70 19___, to 10-16, 1970, that (I) (we) last saw the deceased alive on 10-16 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	M.D.	☑	☐	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/18/70	CAREY'S CEMETERY	FRANKFORD, SUSSEX, DEL.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
A. Douglas Melson	Frankford, Del.	OCT 29 1970	Burrell D. Rogers

VR A15 (4)
45M - 1/69

1

15839

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Wallace	Middle:	Last: BARNES	2a. DATE OF DEATH Month: OCTOBER Day: 24 Year: 1970	2b. HOUR: 9 55 M	
3. SEX: MALE	4. RACE: Col	5. DATE OF BIRTH: 10/24/70	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS: 6 / MIN.: 0
7a. BIRTHPLACE (State or foreign country): Wisconsin	7b. CITIZEN OF WHAT COUNTRY?: U S A.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 138 Davis St	
14. FATHER'S NAME First Middle Last: Walter Williams		15. MOTHER'S MAIDEN NAME First Middle Last: Mattie Barnes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT Address: Josephine Thomas			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Fetal obstetrics — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6hrs
DUE TO, OR AS A CONSEQUENCE OF (b): Immaturity (1010 grams)
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
777X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/24/70, 19____, to 10/24/70, 19____, that (I) (we) last saw the deceased alive an 10/24/70 19____, and that in (my) (our) apinian death accurred an the date and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Chester Collins Jr. DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 10/24/70

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-28-70	23c. NAME OF CEMETERY OR CREMATORY: Green Acres Memo.	23d. LOCATION (City or Town) (County) (State): Salisbury Wico. Md	
24. FUNERAL DIRECTOR: Booker M. West	ADDRESS	25a. REC'D BY REGISTRAR DATE: NOV 2 1970	25b. REGISTRAR'S SIGNATURE: Burrid D. Rogers	

VR A15 (1)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15840 15864

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
4SM - 1/68

1. DECEASED-NAME (Type or print) First: William	Middle: O	Last: Bloard	2a. DATE OF DEATH: Month October Day 8 Year 1970
2b. HOUR: 10:45 P M			
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: 1-1-1878	6. AGE (In years last birthday): 92 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Va	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Quantico	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Route #1, Box 114			
14. FATHER'S NAME First: Wm	Middle:	Last: Blood	15. MOTHER'S MAIDEN NAME First: Lela ? Middle:	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: WW I (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-10-2559	17. INFORMANT: Lena Bloard.	Address:

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sq. cell carcinoma of tongue with carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 years
1419
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from September 28 19 70, to October 8, 19 70, that (I) (we) last saw the deceased alive on October 8 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X] — 22c. DATE SIGNED: 10/9/70

22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr., M.D. — 22e. ADDRESS: Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried	23b. DATE: 10-12-70	23c. NAME OF CEMETERY OR CREMATORY: Green Acres Mem Pk	23d. LOCATION (City or Town): Salisbury	(County): Wico	(State): Md

24. FUNERAL DIRECTOR — ADDRESS: Booker on West — 25a. REC'D BY REGISTRAR DATE: OCT 13 1970 — 25b. REGISTRAR'S SIGNATURE: Bessie F. Rogers

15841

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15865

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Salisbury Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
d. STREET ADDRESS: RD I
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORAGE Middle OLIVER Last CAMPBELL
4. DATE OF DEATH: Month 10 Day 29 Year 1970

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 30, 1910
9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (County & State, or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: David T. Campbell
14. MOTHER'S MAIDEN NAME: Sophrina White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 222-01-5771
17. INFORMANT: Agnes Campbell — Address: Delmar, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 weeks
4339
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8, 1970, to 10-28, 1970 that (I) (we) last saw the deceased alive on _____ 19__, and that death occurred at 4:15 A M, from causes and on the date stated above.

22a. SIGNATURE: William B. Ellis Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 10-30-70
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 11/1/70
23c. NAME OF CEMETERY OR CREMATORY: Melson's Lem
23d. LOCATION (City or Town) (County) (State): Delmar Wicomico Md

24. FUNERAL DIRECTOR: William L. Merrill — ADDRESS: Delmar Del
25a. REC'D BY REGISTRAR: NOV 2 1970 — DATE
25b. REGISTRAR'S SIGNATURE: Bettie S. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

3 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15842 15866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 441
45M - 1-69

1. DECEASED-NAME (Type or print) First: T. Middle: Thurman Last: Carmean	2a. DATE OF DEATH Month: October Day: 20 Year: 1970	2b. HOUR: 2:03 PM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Oct. 3, 1922	6. AGE (In years last birthday): 48 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Truck
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☐ NO ☑ 13e. STREET AND NUMBER:
14. FATHER'S NAME First Middle Last: G. Cleveland Carmean	15. MOTHER'S MAIDEN NAME First Middle Last: Bertha Kelley		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220 12 1306	17. INFORMANT Address: Mrs. Angela W. Carmean, Snow Hill Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MALIGNANT MIXED TUMOR SALIVARY GLAND (L) in SUBMAXILLARY — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 YRS
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1429

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from June 1, 1964, to Oct 20, 1970, thot (I) (~~we~~) last saw the deceased alive an 10/20 1970, and thot in (my) (~~our~~) opinian death accurred on the date and haur and from the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: John M Bloxom III M.D.	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/20/1970	
22d. PHYSICIAN'S NAME (Type): John M. Bloxom III	22e. ADDRESS: MEDICAL CENTER, SALISBURY, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 23, 1970	23c. NAME OF CEMETERY OR CREMATORY: Bates Methodist	23d. LOCATION (City or Town) (County) (State): Snow Hill Md.
24. FUNERAL DIRECTOR ADDRESS: Herman F. Henry, Snow Hill, Md.	25a. REC'D BY REGISTRAR DATE: OCT 26 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers	

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15843

CERTIFICATE OF DEATH

15867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOYCE	ANN	CHURCH	October 18 1970	2:15AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	July 20, 1931	39 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	House work	----

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES [X] NO [ ]	301 S. Haven Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Benjamin		White	Susie		Keeter

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Husband) Address
No	214-28-8216	Mr. Gwyne A. Church, Salisbury, Maryland same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic alcoholism
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/14, 19 70 to 10/18, 19 70, that (I) (we) last saw the deceased alive on 10/18, 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Sally Beardsley	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]	October 19 1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. E. M. Beardsley	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	October 21, 1970	Wicomico Memorial Park	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 26 1970	Bettie D. Rogers

VR A15 14
45M - 1/69

1 2

15844

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15868

1. DECEASED-NAME (Type or print) First Middle Last: Harry George Crow	2a. DATE OF DEATH: 10 Month 11 Day 1970 Year	2b. HOUR: M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 6/22/1893	6. AGE (In years last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Va.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer & waterman	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Talbot	13c. CITY OR TOWN: Bellevue	13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last: Algie Crow		15. MOTHER'S MAIDEN NAME First Middle Last: Mary Bafford	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no	16b. SOCIAL SECURITY NO.: 218-34-9715	17. INFORMANT Address: Irvin M. Crow, Tilghman, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

4339

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe Pulmonary Emphysema.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 7/15, 1970, to 10/14, 1970, that (I) (we) last saw the deceased alive on 10/10 1970 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(we) (did)~~ (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 10/13/70

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/14/1970	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial Park	23d. LOCATION (City or Town) (County) (State): Easton, Md.
24. FUNERAL DIRECTOR ADDRESS: Neunam Funeral Home, Easton, Md.		25a. REC'D BY REGISTRAR DATE: OCT 16 1970	25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15845 — 15869

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First LAURIE Middle ANN Last CURTIS
2a. DATE OF DEATH: Month October Day 27 Year 1970
2b. HOUR: 9:35 P M
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 5-19-1966
6. AGE (In years last birthday): 4 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN
7a. BIRTHPLACE (State or foreign country): DELAWARE
7b. CITIZEN OF WHAT COUNTRY?: U.S.A
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: WICOMICO Md.
10. CITY OR TOWN OF DEATH: SALISBURY
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 710 FERNDALE RD
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NEVER WORK
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: WICOMICO
13c. CITY OR TOWN: SALISBURY
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 710 FERNDALE RD.
14. FATHER'S NAME First JOHN Middle W. Last CURTIS
15. MOTHER'S MAIDEN NAME First BARBARA Middle Last FREESE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: NONE
17. INFORMANT: JOHN W. CURTIS, SEE SEC 13. Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant pelvic tumor of mesenchymal origin
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx 6 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 5/5/70
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Malignant tumor (as in Section 18)
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/5, 1970, to 10/27, 1970, that (I) (we) last saw the deceased alive on 10/22 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alfred C. Kolls MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/27/70
22d. PHYSICIAN'S NAME (Type): ALFRED C. KOLLS
22e. ADDRESS: Medical Center Salisbury Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 10-27-1970
23c. NAME OF CEMETERY OR CREMATORY: John Hopkins Univ. School of Medicine
23d. LOCATION (City or Town) (County) (State): Baltimore Balt. Md.
24. FUNERAL DIRECTOR: Hill Funeral Home ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: OCT 30 1970
25b. REGISTRAR'S SIGNATURE: Burton D. Pearson

VR A10 (R)
45M - 1-70

1

15846

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15870

1. DECEASED-NAME (Type or print) First: Daniel Middle: William Last: Davis	2a. DATE OF DEATH Month: October Day: 19 Year: 1970
2b. HOUR: 1 40 A M	
3. SEX: Male	4. RACE: White
5. DATE OF BIRTH: Oct 19 1970	6. AGE (In years last birthday) YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. 8
7a. BIRTHPLACE (State or foreign country): Md	7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Del	13b. COUNTY: Sussex
13c. CITY OR TOWN: Delmar	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 306 Grove St.	
14. FATHER'S NAME First: Wm. Middle: Last: Davis	15. MOTHER'S MAIDEN NAME First: Nancy Middle: Last: Smarte
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) — (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. —
17. INFORMANT: Wm Davis Address: Delmar Del	

80
46
3

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Immaturity (Birthwt 675 gms) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx 8 hrs

777X

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

2

22a. I certify that (I) (this hospital) attended the deceased from 10/18, 1970, to 10/19, 1970, that (I) (we) last saw the deceased alive on 10/18 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Alfred C Kolb MD DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/19/70
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS: Medical Center Salisbury, Maryland

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/21/70	23c. NAME OF CEMETERY OR CREMATORY: St Stephen Cem	23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del
24. FUNERAL DIRECTOR: William S Morrel ADDRESS: Delmar Del.		25a. REC'D BY REGISTRAR DATE: OCT 20 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogerson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

1

15847

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15871

1. DECEASED-NAME (Type or print) First: Doris Middle: LEE Last: Disharoon	2a. DATE OF DEATH Month: October Day: 2 Year: 1970	2b. HOUR 9:23 P M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: APRIL 26, 1919	6. AGE (In years last birthday) 51 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: ----
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [X] NO [ ] 13e. STREET AND NUMBER: 411 Mount Street
14. FATHER'S NAME First: Millard Middle: Bryan Last: Williams		15. MOTHER'S MAIDEN NAME First: Nettie Middle: May Last: Elliott	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 217-10-3712	17. INFORMANT (Husband) Address: 411 Mount St. Mr. Howard V. Disharoon, Jr., Salisbury, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic bronchitis

491X

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Severe pulmonary emphysema -

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from ~~10~~ 9/29 1970, to 10/2, 1970, that (I) (we) last saw the deceased alive on 10/2 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE [signature] DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] 22c. DATE SIGNED 10/2/70.

22d. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley 22e. ADDRESS Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 5, 1970	23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery	23d. LOCATION (City or Town) (County) (State): R.D., Salisbury, Maryland
24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE OCT 8 1970	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

13

15848

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Item #6, Film G429 10/22/70 km

15872

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, prepare funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Lucy	Middle: Lee	Last: Dorsey	2a. DATE OF DEATH: Month October Day 8 Year 1970 — 2b. HOUR: 7:45 P M
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: 2-2-17	6. AGE (In years last birthday): 53 YRS. 60 — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Bowling Green Ky.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: St. Mary's	13c. CITY OR TOWN: California	13d. INSIDE CITY LIMITS? YES ☐ NO ☐ — 13e. STREET AND NUMBER: Star Rt. 550
14. FATHER'S NAME First: Connor Middle: Lewis Last:	15. MOTHER'S MAIDEN NAME First: Bessie Middle: Christopher Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Brenda Dorsey	Address: Silver Spring. 70 Wendall

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

485X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): diabetes mellitus Arteriosclerotic heart disease; quadriplegia due to multiple emboli;

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 9/28, 19 70, to 10/8, 19 70, that ~~I~~ (we) last saw the deceased alive on 10/8 19 70, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: C.H. Winnacott M.D.	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 10/9/70	
22d. PHYSICIAN'S NAME (Type): C.H. Winnacott, M.D.	22e. ADDRESS: Deer's Head Hospital; Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-12-70	23c. NAME OF CEMETERY OR CREMATORY: Church Cemetary	23d. LOCATION (City or Town): California	(County): St. Mary's	(State): Md.
24. FUNERAL DIRECTOR: Jolley Mem. Chapel	ADDRESS: Green Rd. Salis. Md.	25a. REC'D BY REGISTRAR DATE: OCT 15 1970	25b. REGISTRAR'S SIGNATURE: Billie D. Rogers		

VR A15-1(R) 45M - 1-69

1

15849

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
SARAH	FRANCES	DOVE	October	26	1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	March 24, 1899	71 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Delaware	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	417 Franklin Avenue	Dispatcher	Taxi Company

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	417 Franklin Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Monroe	Washington	Ellis	Elisa	Lavinia	Morris

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (niece) Address
No	221-05-6765	Mrs. Helen L. Porter, 402 Lincoln Ave. Delmar, Delaware

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	10'
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerosis	10 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)		

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertension

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Nov, 1968, to 10/26, 1970, that (I) (we) last saw the deceased alive on 10/26 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Frank L Weaver	MD		☒	☐	October 27/1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Frank L. Weaver	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 29, 1970	St. Stephens Cemetery	Delmar, Sussex, Delaware

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 30 1970	Bertie D. Register

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15850

CERTIFICATE OF DEATH

15874

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR-A15 (4)
25M 1/67

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Salisbury Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: 318 Lillian St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: IRA. Middle: CLIFTON Last: ELLIS

4. **DATE OF DEATH**: Month: Oct Day: 18 Year: 19 70

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 3, 1890

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Truck Driver

11. BIRTHPLACE (County & State, or foreign country): Del.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Barkley Ellis

14. MOTHER'S MAIDEN NAME: Sarah Lowe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-03-3291

17. **INFORMANT** Address: Mrs John Kenney Hebron, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Colon
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): generalized metastasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 9/24, 19 70 to 10/18, 19 70, that (I) (we) last saw the deceased alive on 10/18, 19 70, and that death occurred at ____ M, from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 10/21/70

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 10/22/70

23c. NAME OF CEMETERY OR CREMATORY: Ralph Hill Com.

23d. LOCATION (City or Town) (County) (State): Delmar, Sussex Del

24. FUNERAL DIRECTOR: Wilbur D. Morrell ADDRESS: Delmar Del.

25a. REC'D BY REGISTRAR DATE: OCT 26 1970

25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (6)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15851 — 15875

1. DECEASED-NAME (Type or Print) First: BONNIE Middle: LEE Last: Entry		2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month Day Year: 10-30-70	2b. HOUR: 1:51 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 1-16-1956	6. AGE (In years last birthday): 14 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.
2c. DATE PRONOUNCED DEAD Month 10 Day 30 Year 70			2d. HOUR: M
7a. BIRTHPLACE (State or foreign country): Pa.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula Gen. Hosp	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Student	12b. KIND OF BUSINESS OR INDUSTRY: High School
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Delaware	13b. COUNTY: Sussex	13c. CITY OR TOWN: Delmar	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Wieland Dr. Pk.			
14. FATHER'S NAME First: James Middle: W. Last: Entry		15. MOTHER'S MAIDEN NAME First: Anna Middle: Mae Last: Deemer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: —	17. INFORMANT: Mr James W. Entry ADDRESS: See Sec 13	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fracture dislocation cervical spine — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.: 1:30 P.M. 10-30-70	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Passenger in auto involved in accident.	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): highway,	21f. LOCATION Street or R.F.D. No. City or Town County State: 2½ miles s north of Delmar, Sussex, Del.	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 109 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: Nov. 2, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 11-2-1970	23c. NAME OF CEMETERY OR CREMATORY: Sp. Hill Mem. Garden	23d. LOCATION (City or Town): Salisbury	(County): Wic. (State): Md.
24. FUNERAL DIRECTOR: Hill Funeral Home	ADDRESS: Salisbury, Md.	25a. REC'D BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon B. Randall	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15852 — 15876 D.S.T.

1. DECEASED-NAME (Type or print): First John Middle Glenmore Last EVANS
2a. DATE OF DEATH: Month Oct Day 21 Year 1970
2b. HOUR: 11:45 P.M.
3. SEX: Male
4. RACE: Caucasian
5. DATE OF BIRTH: 11/3/1886
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): Snow Hill, Md.
7b. CITIZEN OF WHAT COUNTRY? U.S.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury, Md.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wicomico Nursing Home, Boot Street
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Restaurant Operator
12b. KIND OF BUSINESS OR INDUSTRY: Food
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Worcester
13c. CITY OR TOWN: Snow Hill
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Federal Street
14. FATHER'S NAME: First T. Middle Franklin Last Evans
15. MOTHER'S MAIDEN NAME: First Elnora Middle Last White
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 220329720A
17. INFORMANT: Address: Mrs. Lillian Figgs Snow Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4369

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10/12/70, 19___, to 10/21/70, 19___, that (I) (we) last saw the deceased alive on 10/21/70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/22/70
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: Oct. 24, 1970
23c. NAME OF CEMETERY OR ~~CREMATORY~~: Bates Methodist
23d. LOCATION (City or Town) (County) (State): Snow Hill, Md.
24. FUNERAL DIRECTOR: Dennis Funeral Home ADDRESS: Snow Hill, Md
25a. REC'D BY REGISTRAR DATE: OCT 26 1970
25b. REGISTRAR'S SIGNATURE: B. Fred. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 10
45M - 1X68

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (carbon papers) Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00 22 1 2 1

VR A15 (4)
45M - 1/69

15853

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15878

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JAY	GOULD	FARLOW	October 19 1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	October 16, 1892	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	R.D. 1, Union Church Rd.	Farmer	Farming

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury		R.D. 1, Box 400

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
George	Washington	Farlow	Henrietta		Parker

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Sister-in-law) Address same as 13e
No	220-34-9368	Mrs. Nellie T. Wimbrow, Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

185X

IMMEDIATE CAUSE (a) Carcinoma prostate — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cardio vascular renal disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 70, to 10-20, 19 70, that (I) (we) last saw the deceased alive on 10-16 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Philip A. Insley	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	October 20/1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Philip A. Insley	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 21, 1970	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 26 1970	Bettie D. Rogers

1

15854

15879

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

Sarah

1. DECEASED-NAME (Type or print) First: SaRAh Middle: A. Lost: Fields	2a. DATE OF DEATH Month Day Year: 10-25-70	2b. HOUR: M	
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: 2-10-1875	6. AGE (In years last birthday) 95 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wicomico Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Somerset	13c. CITY OR TOWN: Marion Sta.	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Rt. 1 Box 212			
14. FATHER'S NAME First: Emerson Middle: Logan Lost:	15. MOTHER'S MAIDEN NAME First: Martha Middle: Cropper Lost:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 216-14-2300	17. INFORMANT: Marie L. Handy Address:	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: 4369

IMMEDIATE CAUSE (a): Cerebro Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Weeks

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis — yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Fractured left hip.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/19/70 19___, to 10/26/70, that (I) (we) last saw the deceased alive on 10/23/79 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Andrew C. Mitchell DEGREE	ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/26/70
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): Kingston	23b. DATE: 10/28/70	23c. NAME OF CEMETERY OR CREMATORY: Kingston	23d. LOCATION (City or Town) (County) (State): Marion Md
24. FUNERAL DIRECTOR: Anthony E. Ward	ADDRESS: Crisfield Md.	25a. REC'D BY REGISTRAR DATE: NOV 2 1970	25b. REGISTRAR'S SIGNATURE: Betty J. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

19 15855

15880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
FAIRFAX	------	FONES	October 10 1970	10:43 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	August 25, 1905	65 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Virginia	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Disposal Operator Experimental	Plant

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES [ ] NO [ ]	1009 Bell Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Getta		Fones	Ellen		McGuire

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) Address same as 13e
No	222-01-0819	Mrs. Essie G. Fones, Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerosis obliterans — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary insufficiency — 2 mos
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4119

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Oct 1	Arterial insufficiency	YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-1, 19 68, to 10-10, 19 70, that (I) (we) last saw the deceased alive on 10-10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
E. Kent Carney		[X]	[ ]	[ ]	October 12 /1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
E. Kent Carney, M.D.	Medical Center, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 14, 1970	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 15 1970	Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15(4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15856

CERTIFICATE OF DEATH

15881

1. DECEASED-NAME (Type or print): First Lafayette Middle Lost Furbush
2a. DATE OF DEATH: Month 10 Day 17 Year 70
2b. HOUR: 2:50 PM
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 6/21/1879
6. AGE (In years last birthday): 91 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY? U.S
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Salisbury Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.): Farmer
12b. KIND OF BUSINESS OR INDUSTRY: Self Employed
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md
13b. COUNTY: Wicomico Wetipquin
13c. CITY OR TOWN
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER
14. FATHER'S NAME First Perry Middle D. Lost Furbush
15. MOTHER'S MAIDEN NAME First Nancy Middle Perry Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 220-34-9002
17. INFORMANT: Mrs Melissa Furbush Address: Wetipquin

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b): Cerebral arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day / yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 10/15, 19 70 to 10/17, 19 70 that (I) (we) last saw the deceased alive on 10/17/70, 19 70, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature]
DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 10/19/70
22d. PHYSICIAN'S NAME (Type)
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10/20/70
23c. NAME OF CEMETERY OR CREMATORY: Wetipquin Cem.
23d. LOCATION (City or Town) (County) (State): Wetipquin, Md.
24. FUNERAL DIRECTOR: C. M. Messick
ADDRESS: Bivalve, Md.
25a. REC'D BY REGISTRAR DATE: OCT 22 1970
25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers

VR A15 (4) 30M REV. 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

15857

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ANNIE	H	GILES	October	3,	1970	9:15 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	Negro	Apr. 27, 1923	47 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Deer's Head State Hospital	Laborer	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Somerset	Pocomoke	YES [ ] NO [X]	R.F.D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	H.	Turner	Lovie		King

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or Unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No		173-22-3461	Floyd Giles	Pocomoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Intestinal Obstruction due to Adhesions — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Malnutrition and Pancreatitis (Chronic)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspital) attended the deceased from August 24, 1970, to October 3, 1970, that (I) (we) last saw the deceased alive an October 3, 19 70, and that in (my) (our) apinion death occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L. V. Maldve, MD	MD		[ ]	[X]	10/5/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. V. Maldve, M.D.	Deer's Head State Hospital, Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	10-10-70	Christ Cem.	Pocomoke	Wor.	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Warren Lay	New Church, Va.	OCT 13 1970	Bessie D. Rogers

VR A15 (2)
45M - 1X69

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15858

CERTIFICATE OF DEATH

15884

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: All life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 693 Fitzwater St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: 693 Fitzwater St. — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: ORA — Middle: — Last: Hardy

4. **DATE OF DEATH**: Month: 10 — Day: 13 — Year: 1970

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: 3-31-83

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Jesterville Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Noah Jones

14. MOTHER'S MAIDEN NAME: Mary Turner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. **INFORMANT** — Address: Leza Turner, Jesterville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease
DUE TO (b): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Indefinite

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1 Sept 19 70 to 13 Oct 19 70 that (I) (we) last saw the deceased alive on 13 Oct 19 70 and that death occurred at 8 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Darrell F. Purnell M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 15 Oct 70

22c. PHYSICIAN'S NAME (Type): F. A. PURNELL MD — 22d. ADDRESS: Salisbury Md 21801

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 10-17-70 — 23c. NAME OF CEMETERY OR CREMATORY: Elzey United — 23d. LOCATION (City, town or county) (State): Jesterville, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Colley Mem. Chapel — ADDRESS: Sal. S. Md.

25a. REC'D BY REGISTRAR DATE: NOV 9 1970 — 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A1S (4)
20M S-63

1

15859

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15883

1. DECEASED-NAME (Type or print) First: Booker Middle: Last: Hargis	2a. DATE OF DEATH Month: Oct. Day: 29 Year: 1970
2b. HOUR: 5:40 A.M.	
3. SEX: Male	4. RACE: Negro
5. DATE OF BIRTH: Apr. 23, 1916	6. AGE (In years last birthday): 54 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Truck Driver
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester
13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Rt. #2, Box 87	
14. FATHER'S NAME First: Louis Middle: Last: Hargis	15. MOTHER'S MAIDEN NAME First: Drucilla Middle: Last: Waters
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.
17. INFORMANT: Laura Hargis Address: Pocomoke Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Septicemia	12 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Bronchopneumonia	18 days
DUE TO, OR AS A CONSEQUENCE OF (c)		

485X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic pulmonary emphysemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (X) (this hospital) attended the deceased from 10/5, 19 70, to 10/29, 19 70, that (X) (we) last saw the deceased alive on 10/29 19 70, and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (XXX) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED: 10/29/70
22d. PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11-1-70
23c. NAME OF CEMETERY OR CREMATORY: Johnsonneck Cem.	23d. LOCATION (City or Town) (County) (State): Pocomoke Wor. Md.
24. FUNERAL DIRECTOR: [signature] ADDRESS: New Church, Va.	25a. REC'D BY REGISTRAR DATE: NOV 4 1970
25b. REGISTRAR'S SIGNATURE: Lemon R. Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

15860

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15886

1. DECEASED-NAME (Type or print) First: Willa Middle: — Last: HARRIS	2a. DATE OF DEATH Month: OCTOBER Day: 16 Year: 1970	2b. HOUR 12 20 A M	
3. SEX: Female	4. RACE: Col	5. DATE OF BIRTH: 11-1-84	6. AGE (In years last birthday) 85 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Texas	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Domestic	12b. KIND OF BUSINESS OR INDUSTRY: none
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET AND NUMBER: 305 Poplar Hill Ave
14. FATHER'S NAME First Middle Last: unknown		15. MOTHER'S MAIDEN NAME First Middle Last: unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ~~or unknown~~ (If yes give war or dates of service): no	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: S Turner Address	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

4369

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-14, 1970, to 10-16, 1970, that (I) (we) last saw the deceased alive on 10-16 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John G Bulkeley M.D. DEGREE	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-16-70	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-17-70	23c. NAME OF CEMETERY OR CREMATORY: Drum Acres Cem	23d. LOCATION (City or Town) (County) (State): Salisbury Wico Md
24. FUNERAL DIRECTOR: Booker M West.	ADDRESS	25a. REC'D BY REGISTRAR DATE: OCT 21 1970	25b. REGISTRAR'S SIGNATURE: Bittie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS-14) 45M 1/69

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15887

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1. DECEASED-NAME (Type or Print)	First: JAMES	Middle: CLEVELAND	Last: HILGHMAN	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒	Month: 10	Day: 1	Year: 19 70	2b. HOUR: 6 A M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: March 25, 1889	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month October Day 1 Year 1970		2d. HOUR: 8:30 A M	
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: WICOMICO						Md.
10. CITY OR TOWN OF DEATH: Hebron	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 104 Bradley Street	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Lumberman	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Hebron	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: 104 Bradley Street					
14. FATHER'S NAME First: George	Middle	Last: Hilghman	15. MOTHER'S MAIDEN NAME First: Elizabeth	Middle	Last: Brumbley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-03-3266	17. INFORMANT (Wife) ADDRESS same as 13e: Mrs. Eula B. Hilghman, Hebron, Maryland							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): 409 Camden Ave., Salisbury, Maryland

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: October 2 /1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 3, 1970	Springhill Memory Gardens	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 6 1970	J Charles Judge

1

FOR STATE HEALTH DEPT.

15862

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15888

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MV 93. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last
GEORGE	TURLINGTON	HOLLAND

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month 10 Day 3 Year 1970 — 2b. HOUR 2:15 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
M	W	10-20-21	48 YRS.				

2c. DATE PRONOUNCED DEAD Month 10 Day 3 Year 1970 — 2d. HOUR M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Md.	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	mechanic	garment

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Wicomico	Salisbury	YES [X] NO [ ]	113 Princeton Ave.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
George Thomas Holland	Eva Mae Turlington

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (wife) ADDRESS
Yes W.W. II	219-07-5839	Mrs. Phyllis Holland, as per #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Earl L Royer M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md. ADDRESS(Street, city, town, or county)

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED Oct. 5, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
burial	10-6-70	First Baptist Cemetery	Pocomoke, Wor., Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Robert L Watson	Watson Funeral Home, Pocomoke, Md.	OCT 9 1970	J Charles Judge

VR A15ME (5) 10M - 1/69

1

FOR STATE HEALTH DEPT.

15863

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15889

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last			2a. DATE KNOWN [X] OF DEATH ESTIMATED [ ] Month Day Year	2b. HOUR
BENJAMIN	EDWARD	HUNTINGTON			10-9-70 19	6:50 P M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Nov. 17, 1891	78 YRS.			October 9 19 70	11 M
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH				
Delaware	USA		WICOMICO Md.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury	Peninsula General Hospital	Carpenter					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER			
Maryland	Wicomico	Parsonsburg	YES [ ] NO [ ]	-----			
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last		
James		Huntington	Ella		Collins		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMAN (Wife) ADDRESS				
Yes	WW I	213-14-6023	Mrs. Ethel P. Huntington, Parsonsburg, Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22b. DATE SIGNED: October 12 /1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 12, 1970	Parsonsburg Cemetery	Parsonsburg, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	DATE RECEIVED BY REGISTRAR	26b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 13 1970	Bettie J. Rogers

VR A15ME (S) 8M-1/70

1

15864

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15890

1. DECEASED-NAME (Type or print) First: William Middle: O Lost: Jarman	2a. DATE OF DEATH Month: October 9 Day: 1970 Year:	2b. HOUR: 1:30 A M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: JAN. 27, 1903	6. AGE (In years last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY: SELF EMP
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Berlin	13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET AND NUMBER: Box 304
14. FATHER'S NAME First: PETER Middle: Lost: JARMAN	15. MOTHER'S MAIDEN NAME First: ROSA Middle: Last: FOSKEY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO.: 219-07-1936	17. INFORMANT Address: Mrs W. O. JARMAN BERLIN MD	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Bronchopneumonia	2 days
DUE TO, OR AS A CONSEQUENCE OF (b)	cor Chronic/pulmonale	Years
DUE TO, OR AS A CONSEQUENCE OF (c)	Chronic emphysema	Years

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from September 1, 1970, to October 9, 1970, that (I) (we) last saw the deceased alive on October 9 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles H Winnacott M.D. DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type): Charles H. Winnacott, M.D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/12/70	23c. NAME OF CEMETERY OR CREMATORY: JARMAN	23d. LOCATION (City or Town) (County) (State): WHALEYSVILLE Wbr. MD
24. FUNERAL DIRECTOR: Anna J. Burbage	ADDRESS: Berlin Md	25a. REC'D BY REGISTRAR DATE: OCT 13 1970	25b. REGISTRAR'S SIGNATURE: Bettie J. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

91

23

2

2

1

VR A15 (4) 45M 1/69

1

15865

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15891

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First Thelma; Middle Polk; Last Johnson
2a. DATE OF DEATH: Month October; Day 21; Year 1970
2b. HOUR: 6:15 PM
3. SEX: Female
4. RACE: Negro
5. DATE OF BIRTH: 03-15-29
6. AGE (In years last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS: HOURS, MIN)
7a. BIRTHPLACE (State or foreign country): Somerset
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife
12b. KIND OF BUSINESS OR INDUSTRY: None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: ~~Salisbury~~ Eden
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Rt. #1 Box 25
14. FATHER'S NAME First Emory; Middle; Last Polk
15. MOTHER'S MAIDEN NAME First Hattie; Middle L.; Last Cannon
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 149-22-7957
17. INFORMANT: Lester Johnson Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
7340
IMMEDIATE CAUSE (a): Acute cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF (b): G.I bleeding
DUE TO, OR AS A CONSEQUENCE OF (c): Scleroderma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this haspital) attended the deceased from October 21, 19 70, to October 21, 19 70, that (I) (we) last saw the deceased alive an October 21 19 70, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (~~did not~~) view the bady after death.

22b. SIGNATURE: H. E. Bondy M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10-21-70
22d. PHYSICIAN'S NAME (Type): H.E. Bondy
22e. ADDRESS: Peninsula General Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 10-25-70
23c. NAME OF CEMETERY OR CREMATORY: West Post Office
23d. LOCATION (City or Town) (County) (State): West Post Office Md
24. FUNERAL DIRECTOR: Baker & West ADDRESS:
25a. REC'D BY REGISTRAR DATE: OCT 26 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

VR A15 (4)
45M - 1/69

2 1 6 15886 Item#2a, Film G428 10/20/70 km

15892

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED Month Day Year	2b. HOUR
HILDA	MARIE	KELLER	Oct. 7 1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	January 21, 1915	55 YRS.					October 7 1970	M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	WIDOWED [X]	WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Office clerk	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES [ ] NO [ ]	302 Cedar Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Woodland	H.	Furniss	Lola		Dayton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Daughter) ADDRESS
No	214-10-7900	Rt. 1 Nutters Cross Rd. Mrs. Susan McGlaughlin, Salisbury, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Subarachnoid Hemorrhage	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

4309

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Ralph A Tosley M.D.

EXAMINER'S NAME (Type) Ralph A Tosley, Salisbury, Md.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED 10-7-70

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 10, 1970	Allen Cemetery	Allen, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 15 1970	Bertie D. Rogers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15867 — 15893

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: GRACE	Middle: A.	Last: Kushela	2a. DATE OF DEATH Month: October	Day: 26	Year: 70	2b. HOUR: 1:55 AM
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 1-18-1924	6. AGE (In years last birthday): 46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): DELA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.				
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FLORIST BUS.	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: DEL.	13b. COUNTY: SUSSEX	13c. CITY OR TOWN: SELBYVILLE	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER			
14. FATHER'S NAME First: CLEVELAND	Middle:	Last: EVANS	15. MOTHER'S MAIDEN NAME First: ANNA	Middle:	Last: EVANS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 222-24-0553	17. INFORMANT: LOUIS KUSHELA	Address: SELBYVILLE			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cardio-Pulmonary Failure	36 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	Post-Pneumectomy	46 hr
DUE TO, OR AS A CONSEQUENCE OF (c)	Bronchial Adenoma	month

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/13, 19 70, to 10/26, 19 70, that (I) (we) last saw the deceased alive on 10/26 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Kenneth M. Given MD	DEGREE	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 10/26/70
22d. PHYSICIAN'S NAME (Type): KENNETH GIVAN	22e. ADDRESS: Medical Center, Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10/29/70	23c. NAME OF CEMETERY OR CREMATORY: RED MENS Cem.	23d. LOCATION (City or Town) (County) (State): SELBYVILLE, SUSSEX, DEL.	
24. FUNERAL DIRECTOR: R. Donald Melson	ADDRESS: Frankford, Del	25a. REC'D BY REGISTRAR DATE: OCT 29 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers	

VR A15 (4)
45M - 1/69

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FilmG430
Item#2a, FilmG430 11/9/70 Kam

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15894

1. DECEASED-NAME (Type or Print) 15868	First: Ruben	Middle:	Last: Lankford
2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: Oct.	Day: 25	Year: 1970
2b. HOUR	M		
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: Aug. 28, 1948	6. AGE (In years last birthday): 22 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.		
2c. DATE PRONOUNCED DEAD	Month: 10	Day: 25	Year: 1970
2d. HOUR	11:55 M		
7a. BIRTHPLACE (State or foreign country): Va.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula Gen. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Farm
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Va.	13b. COUNTY: Accomack	13c. CITY OR TOWN: New Church	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: P.O. Bx. 124			
14. FATHER'S NAME: First Elihue	Middle:	Last: Lankford	15. MOTHER'S MAIDEN NAME: First Tobitha Middle: Joynes Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 226-68-3493	17. INFORMANT: Barbara Lankford ADDRESS: New Church, Va.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY: 4109

IMMEDIATE CAUSE (a) Coronary Occlusion

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Philip A. Insley M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town, or county)

22b. DATE SIGNED: 10-30-70

EXAMINER'S NAME (Type): Philip A. Insley, M.D.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-31-70	23c. NAME OF CEMETERY OR CREMATORY: Dee's Chapel Cem.	23d. LOCATION (City or Town) (County) (State): Horntown Va.
24. FUNERAL DIRECTOR: Samuel Sawyer	ADDRESS: New Church, Va.	25a. REC'D BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15ME (5)
10M REV. 1/68

15869

MARYLAND STATE DEPARTMENT

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15895

1. DECEASED-NAME (Type or print) First Middle Last	Clarence N. Little
2a. DATE OF DEATH Month Day Year	10 23 70
2b. HOUR	6:45 p M
3. SEX	Male
4. RACE	White
5. DATE OF BIRTH	1/3/1885
6. AGE (In years last birthday)	85 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	
IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Pa.
7b. CITIZEN OF WHAT COUNTRY?	U.S.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	
9. COUNTY OF DEATH	Wicomico Md.
10. CITY OR TOWN OF DEATH	Waterview
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Home-Waterview
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	U.S. Navy Ret. Officer
12b. ~~KIND OF BUSINESS OR INDUSTRY~~	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	Md.
13b. COUNTY	Wicomico
13c. CITY OR TOWN	Waterview
13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	—
14. FATHER'S NAME First Middle Last	Charles F Little
15. MOTHER'S MAIDEN NAME First Middle Last	Margaret H Cramer
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	yes 1902-1922
16b. SOCIAL SECURITY NO.	077-12-5853
17. INFORMANT Address	Helga Little, Waterview, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

185X

IMMEDIATE CAUSE (a) Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 month

DUE TO, OR AS A CONSEQUENCE OF (b) Ca of prostate — 3 mo

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

age.

19a. DATE OF OPERATION	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No. City or Town County State	

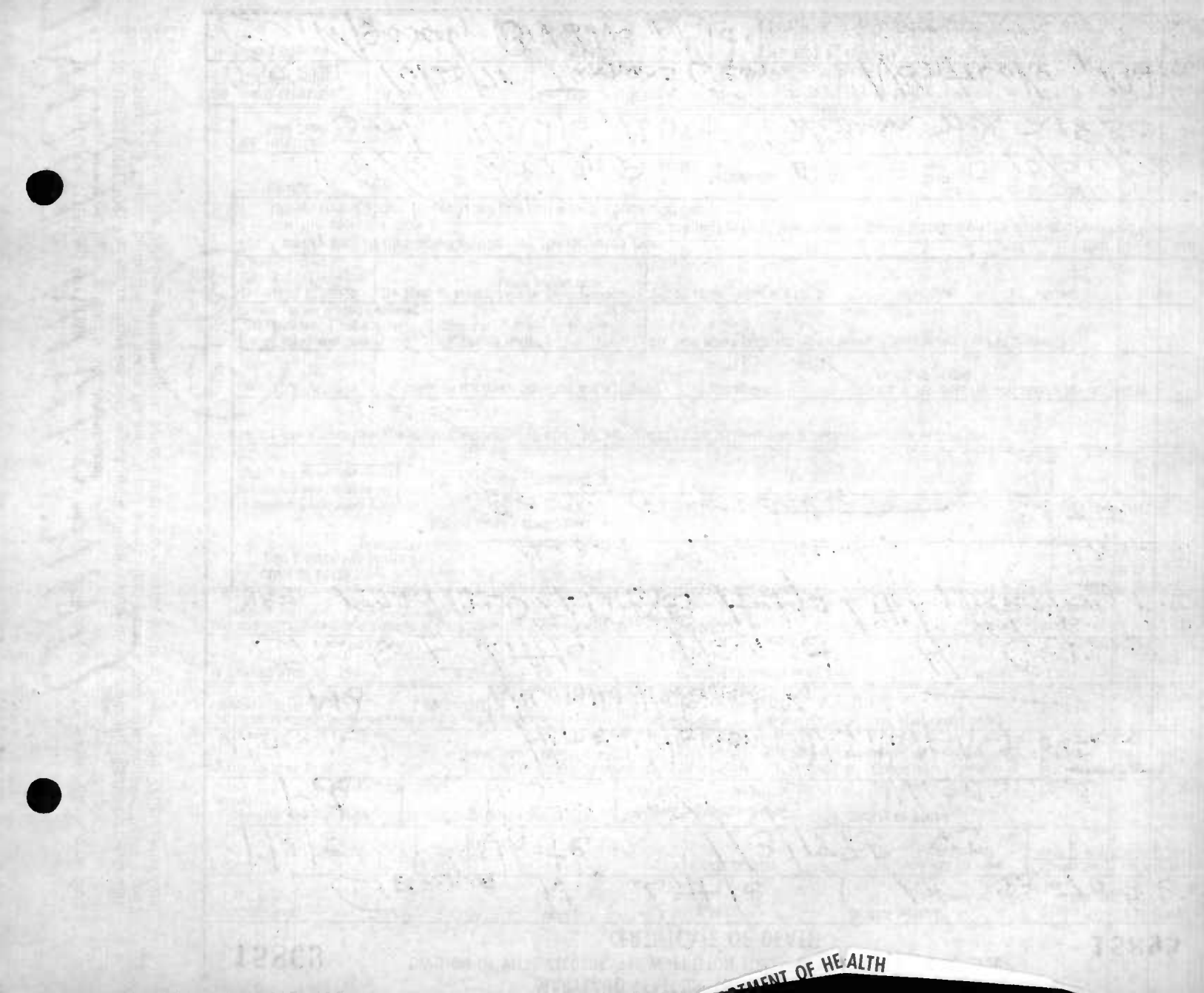
22a. **I certify** that (I) (this hospital) attended the deceased from_____, 19____, to_____, 19____, that (I) (we) last saw the deceased alive on_____19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	S H Hardle MD DEGREE
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	
22c. DATE SIGNED	10/26/70
22d. PHYSICIAN'S NAME (Type)	Seth Hardle, MD.
22e. ADDRESS	Hebron Md 21830
23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial
23b. DATE	10/28/70
23c. NAME OF CEMETERY OR CREMATORY	Turners Cem.
23d. LOCATION (City or Town) (County) (State)	Nanticoke, Md.
24. FUNERAL DIRECTOR ADDRESS	C J Messick, Bivalve, Md.
25a. REC'D BY REGISTRAR DATE	OCT 28 1970
25b. REGISTRAR'S SIGNATURE	Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68


DEPARTMENT OF HEALTH

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

15870

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15896

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month Day Year	2b. HOUR
BESSIE	A.	MAC ALLEN	X	10-16-70	9:55 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD	2d. HOUR
F	W	9-9-1890	80 YRS.			Month 10 Day 16 Year 1970	M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED X; NEVER MARRIED ☐; WIDOWED ☐; DIVORCED ☐	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Somerset	Princess Anne	YES ☐ NO ☐	Box 276

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
LEVIN R. POLLITT	EMMA PEYTON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
		HAROLD MAC ALLEN PR. ANNE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Broncho pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

485 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO X

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection X, Inquiry X, and in my opinion death resulted from Naturol couses X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE _____ M.D.

EXAMINER'S NAME (Type) Earl L. Royer, M.D.

ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED Oct. 16, 1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	10/18/1970	MANOKIN PRES. CEMETERY	PRINCESS ANNE, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Levin Wilson, Princess Anne, Md.	OCT 20 1970	Bertie D. Rogers

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
8M-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15871 — 15897

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: ----	Last: Mailand	2a. DATE OF DEATH: Month October, Day 20, Year 1970	2b. HOUR: 10 P.M.
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: December 20, 1902	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Holland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: WICOMICO Md.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Nurseryman	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: R.D. 5, Spring Hill Road	
14. FATHER'S NAME First: Frederick Willem	Middle	Last: Mailand	15. MOTHER'S MAIDEN NAME First: Tryntje	Middle	Last: de Vries
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-32-2339	17. INFORMANT (Sister-in-law) Address same as 13e: Mrs. Frances W. Brumbley, Salisbury, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Hypertension & Arteriosclerotic Vascular disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 10-15 –, 19 70, to 10-20, 19 70, that (I) (~~we~~) last saw the deceased alive on 10-20-70 19___, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (did ~~not~~) view the body after death.

22b. SIGNATURE: James L. Clifford M.D.	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/20/70	
22d. PHYSICIAN'S NAME (Type): JAMES L. CLIFFORD	22e. ADDRESS: MEDICAL CENTER, Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 23, 1970	23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens	23d. LOCATION (City or Town): Salisbury	(County): Wco (State): Md
24. FUNERAL DIRECTOR: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	ADDRESS	25a. RECD BY REGISTRAR DATE: OCT 27 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers	

VR A15 (1) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15872 — 15898

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	MARY / L. / MALONE	2a. DATE OF DEATH Month / Day / Year	October 7 1970
2b. HOUR	10:15 PM		
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH	April 16, 1891	6. AGE (In years last birthday)	79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. COUNTY OF DEATH	WICOMICO Md.
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Peninsula General Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housework	12b. KIND OF BUSINESS OR INDUSTRY	--
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Wicomico
13c. CITY OR TOWN	Allen	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	
13e. STREET AND NUMBER	-----		
14. FATHER'S NAME First / Middle / Last	Marion / E. / Lankford	15. MOTHER'S MAIDEN NAME First / Middle / Last	Ella / C.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	
17. INFORMANT	(Son) Rt. 4 Mr. John A. Malone, Salisbury, Maryland	Address	N. Schumaker Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung (Rt)
DUE TO, OR AS A CONSEQUENCE OF (b) with Metastases
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying couse last. 1621
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF OEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.O. No. / City or Town / County / State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Aug 31, 1970, to Oct 7, 1970, that (I) (~~saw~~) last saw the deceased alive an Oct 7 1970, and that in (my) (~~our~~) apinion death accurred an the date and haur and fram the causes stated abave, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	Thomas C Hill	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: October 9 /1970
22d. PHYSICIAN'S NAME (Type)	Dr. Thomas C. Hill	22e. ADDRESS	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Oct. 10, 1970	Allen Cemetery	Allen, Wicomico, Maryland	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND		OCT 15 1970	Bertie D. Rogers	

VR A15-41
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15873

CERTIFICATE OF DEATH

15899

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
SARAH	JONES	MARSH	October	16	1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	December 27, 1882	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Pennsylvania	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Salisbury Nursing Home	Housewife	---

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury		Woodland Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	Jones	Philips	Harriett		Chalfont

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Daughter)	Address
No	220-44-3984	Mrs. Harriet M. Craig, Salisbury, Maryland	Woodland Rd.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 mo.
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis — 4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from July 20, 1970, to Oct. 16, 1970, that (I) (we) last saw the deceased alive on Oct. 15, 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
[signature]					Oct. 16 /1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. E. M. Beardsley	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Oct. 19,1970	Atglen Cemetery	Atglen		Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 20 1970	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15874

CERTIFICATE OF DEATH

15900

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ADAM	-----	McCAUGHEY	OCTOBER 31 1970	3:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	White	July 29, 1904	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
England	USA		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Hosiery knitter	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Dorchester	Cambridge	YES ☒ NO ☐	304 Bailey ROAD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		McCaughey	Sarah	Ann	Hamilton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Daughter)	Address
No			Mrs. Shirley Moore	same as 13e, Cambridge, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory failure

DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema & Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

492 X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

ASCVD c Hemiplegia Ca of Prostate c Metastasis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-29, 1970, to 10-31, 1970, that (I) (we) last saw the deceased alive on 10-31 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph C. Fitzgerald	MD	☑	☐	☐	Oct. 31, 1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Joseph C. Fitzgerald, M.D.	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Nov. 4, 1970	North Wales Cemetery	North Wales, Montgomery, Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	NOV 4 1970	Vernon B. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

15875

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: SALLIE	Middle: ANN	Last: McComick	2a. DATE OF DEATH Month: October	Day: 14 Year: 1970	2b. HOUR: 5:30 PM
3. SEX: Female	4. RACE: WHITE	5. DATE OF BIRTH: JULY 16, 1887	6. AGE (In years last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): DEL	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.			
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: DEL.	13b. COUNTY: SUSSEX	13c. CITY OR TOWN: SEAFORD	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER		
14. FATHER'S NAME First: WARREN	Middle: O.	Last: McCABE	15. MOTHER'S MAIDEN NAME First: ANNIE	Middle: E.	Last: McCABE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 221-24-3994	17. INFORMANT: EDWIN McCOMRICK	Address: FRANKFORD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3-4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular Disease — yrs

DUE TO, OR AS A CONSEQUENCE OF (c): Age

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10/4, 19 70, to 10/18, 19 70, that (I) (we) last saw the deceosed alive on 10/18 19 70 and that in (my) (our) opinion deoth occurred on the date and hour and from the couses stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wm R Coffield DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10/21/70	23c. NAME OF CEMETERY OR CREMATORY: ROXANA Cem.	23d. LOCATION (City or Town) (County) (State): ROXANA, SUSSEX, DEL.	
24. FUNERAL DIRECTOR: A. Douglas Melson	ADDRESS: Frankford, Del.	25a. REC'D BY REGISTRAR DATE: OCT 29 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers	

VR A15 (4)
45M - 1/69

15876

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15902

Item#6, Film G42, 10/19/70 km

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Althea	Middle: C.	Last: Molock	2a. DATE OF DEATH Month: Oct. Day: 12 Year: 1970
2b. HOUR: 1:25 P.M.			
3. SEX: Female	4. RACE: Negro	5. DATE OF BIRTH: JULY 20, 1956	6. AGE (In years last birthday): 14 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): STUDENT	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 906 Camelia St.			
14. FATHER'S NAME First: JAMES	Middle	Last: MOLOCK	15. MOTHER'S MAIDEN NAME First: BERNICE Middle	Last: WOOLFORD
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: BERNICE WOOLFORD 906 CAMELIA ST. 21613	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours
486 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Marked Hydrocephalis secondary to old brain abscess

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. I **certify** that (I) (this hospitol) attended the deceased from 7/1, 19 70, to 10/12, 19 70, that (I) (we) lost saw the deceased alive an 10/12 XX 19 70 and that in (my) (our) apinion death occurred on the dote and haur and from the causes stated above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: F. J. Murphy, Jr. M.D.	DEGREE: ATTENDING PHYS. XX ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10/13/70	
22d. PHYSICIAN'S NAME (Type): F. J. Murphy, Jr., M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10/17/70	23c. NAME OF CEMETERY OR CREMATORY: OLDFIELD	23d. LOCATION (City or Town): OLDFIELD	(County): DOR.	(State): MD.
24. FUNERAL DIRECTOR: Frederick C. St. Clair	ADDRESS: ST. CLAIR F. HOME CAMBRIDGE, MD.	25a. REC'D BY REGISTRAR DATE: OCT 16 1970	25b. REGISTRAR'S SIGNATURE: Bittie D. Rogers		

VR A15 (4) 45M - 1/68

1

15877

Item #13, Film G429 10/13/70 km

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15903

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Richard	Lee	Munford ~~XXXXXX~~	10	4	70	12:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Male	Negro	10/4/70	YRS.			1	

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Salisbury	U S A		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Somerset	Westover	YES ☐ NO ☐	RFD

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Richard	Lee	Munford	Sharon		Green

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
			Sharon Green	Westover, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Prematurity

DUE TO, OR AS A CONSEQUENCE OF (b) Premature delivery

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 777X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
J. D. Crutchfield Jr.		☒	☐	☐	10/4/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/5/70	Green	Westover Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William H. James Jr, Princess Anne, Md	OCT 7 1970	Charles Judge

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15878

15904

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
45M - 1-69

1. DECEASED-NAME (Type or print) First: HENRY	Middle: E.	Last: NELSON, JR.	2a. DATE OF DEATH Month: October Day: 7 Year: 1970	2b. HOUR: 12 P.M.	
3. SEX: MALE	4. RACE: CAUCASIAN	5. DATE OF BIRTH: 3 FEB 1886	6. AGE (In years last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 212 TILGHMAN ST.	
14. FATHER'S NAME First: OLAF	Middle	Last: NELSON	15. MOTHER'S MAIDEN NAME First: LOUISA	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 215-03-2647	17. INFORMANT: HENRY E. NELSON, JR.	Address: 212 TILGHMAN ST - SALISBURY, MD. 21801	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs
DUE TO, OR AS A CONSEQUENCE OF
(b): arteriosclerotic Heart Disease. — 6 years
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Carcinoma of Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / Stote

22a. **I certify** thot (I) (~~this hospital~~) attended the deceased from 3/14, 19 64, to 9/27, 19 70, that (I) (we) lost sow the deceased alive an 9/27 19 70, and that in (my) (our) opinion deoth occurred on the dote and haur and from the causes stated above, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Louis D. Jones M.D.	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐
22c. DATE SIGNED: 10/7/70				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10 Oct 70	23c. NAME OF CEMETERY OR CREMATORY: DRUID RIDGE CEMETERY	23d. LOCATION (City or Town) (County) (State): BALTO. CO., MD.	
24. FUNERAL DIRECTOR: ULRICH FUNERAL HOME, BALTO, MD. 21206	ADDRESS	25a. RECD BY REGISTRAR DATE: OCT 13 1970	25b. REGISTRAR'S SIGNATURE: Billie J. Rogers	

1

15879

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15905

1. DECEASED-NAME (Type or print) First: Howard Middle: Beauchamp Lost: Nichols	2a. DATE OF DEATH Month: October Day: 9 Year: 1970	2b. HOUR 1 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: AUG 10, 1903	6. AGE (In years last birthday) 67 YRS. IF UNDER 1 YEAR MONTHS / DAYS IF UNDER 24 HRS. HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Md	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Delmar	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 411 E Elizabeth St			
14. FATHER'S NAME First: Ernest Middle: Lost: Nichols	15. MOTHER'S MAIDEN NAME First: Annie Middle: Beauchamp Lost:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.	17. INFORMANT: Mrs Ann Ring Address: Delmar Del	

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

4124

IMMEDIATE CAUSE (a) Intracranial Hemorrhage.

DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 10-8, 1970, to 10-9, 1970, that (I) (~~we~~) last saw the deceased alive on 10-8 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE: Joseph C. Fitzgerald DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-12-70	
22d. PHYSICIAN'S NAME (Type): Joseph C. Fitzgerald	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10/11/70	23c. NAME OF CEMETERY OR CREMATORY: St Stephens Cem	23d. LOCATION (City or Town) (County) (State): Delmar Sussex Del
24. FUNERAL DIRECTOR: William S Marvel ADDRESS: Delmar Del	25a. REC'D BY REGISTRAR DATE: OCT 19 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogerson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1 2

15880

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15906

1. DECEASED-NAME (Type or print) First: GEORGIA Middle: IRENE Last: Outten	2a. DATE OF DEATH Month: October Day: 5 Year: 1970	2b. HOUR 7 50 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Feb. 22, 1900	6. AGE (In years last birthday) 70 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: --
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Pocomoke	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 714 Fourth Street			
14. FATHER'S NAME First: Warren Middle: -- Last: Mason	15. MOTHER'S MAIDEN NAME First: Middle: -unk- Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service): --	16b. SOCIAL SECURITY NO.: 217-05-6527	17. INFORMANT Address: Linwood C. Outten, Pocomoke City, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

5621

IMMEDIATE CAUSE (a) Peritonitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 days

DUE TO, OR AS A CONSEQUENCE OF (b) Acute Diverticulitis — weeks

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (this hospital) attended the deceased from 9.27, 1970, to 10.5, 1970, that (I) (we) last saw the deceased alive on 10.5 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: H A Briele	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10.6.70	
22d. PHYSICIAN'S NAME (Type): H A Briele	22e. ADDRESS: Medical Center		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 10-7-1970	23c. NAME OF CEMETERY OR ~~CREMATORY~~: Mariners Methodist	23d. LOCATION (City or Town) (County) (State): Crisfield-Somerset-Md.
24. FUNERAL DIRECTOR: Robert H. Watson	ADDRESS: Pocomoke City, Md.	25a. REC'D BY REGISTRAR DATE: OCT 9 1970	25b. REGISTRAR'S SIGNATURE: J Charles Judge

Robert H. Watson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15881 15907

1. DECEASED-NAME (Type or print): First Charles; Middle Winnie; Last Payton
2a. DATE OF DEATH: Month October; Day 21; Year 1970
2b. HOUR: 2 A.M.
3. SEX: Male
4. RACE: Negro
5. DATE OF BIRTH: APRIL, 27, 1896
6. AGE (In years last birthday): 74 YRS. IF UNDER 1 YEAR: MONTHS; DAYS. IF UNDER 24 HRS.: HOURS; MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Deer's Head Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Dorchester
13c. CITY OR TOWN: Church Ck.
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER:
14. FATHER'S NAME First CHARLES; Middle; Last PAYTON
15. MOTHER'S MAIDEN NAME First HARIETT; Middle; Last TRAVERS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 212-18-6222
17. INFORMANT: CORA S. PAYTON Address: CHURCH CREEK, MD. 21622

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pulmonary infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral thrombosis; glaucoma.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (X) (this haspital) attended the deceased from Oct. 7, 1970, to Oct. 21, 1970, that (X) (we) last saw the deceased alive an Oct. 21 19 70, and that in (my) (our) opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Francis J. Murphy Jr. DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 10/21/70
22d. PHYSICIAN'S NAME (Type): Francis J. Murphy, Jr., M.D.
22e. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10/25/70
23c. NAME OF CEMETERY OR CREMATORY: JOHN WESLEY
23d. LOCATION (City or Town) (County) (State): LINERS ROAD DOR. MD.
24. FUNERAL DIRECTOR: Frederick C. DeVair
ADDRESS: STANLEY F. HOME CAMBRIDGE, MD.
25a. REC'D BY REGISTRAR DATE: OCT 27 1970
25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1(6)

15882

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
IRENE	J.	Pepper	October	25	1970	7:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	WHITE	OCT. 31, 1917	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
DEL.	USA	WIDOWED X	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	[illegible]	Sales Summit

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
DEL.	Sussex	Selbyville	YES X NO	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HARRY		BUNTING	MAE		BUNTING

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	222-22-1034	Bruce Pepper	Selbyville

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 30 mins

4002

DUE TO, OR AS A CONSEQUENCE OF

(b) Malignant Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Uremia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10/23, 1970, to 10/23, 1970, that (I) (we) last saw the deceased alive on 10/23 1970 and that in (my) (our) opinion death occurred on the date and haur and fram the causes stoted above (I) (we) (did) (did not) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]		X	☐	X	10/23/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL? (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/26/70	Roxana Cem.	Roxana, Sussex, Del

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. Douglas Mebane	Frankford, Dela.	OCT 29 1970	Bertie D. Rogers

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15883

15909

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Lost
FRANK	HENRY	PETERS

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month	Day	Year	2b. HOUR
10	26	1970	5:24 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.
Male	White	9-30-1879	91 YRS.				

2c. DATE PRONOUNCED DEAD Month	Day	Year	2d. HOUR
10	28	1970	5:24 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Retired Wholesale	Groceries

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	307 E. William St.,

14. FATHER'S NAME First	Middle	Lost	15. MOTHER'S MAIDEN NAME First	Middle	Lost
Charles		Peters	Annie		Timmons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No.	---	214-10-8946	Miss. Edna Peters, See Sec 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) 887X Cerebral Anemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
	10-26-70 19	Fell

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	Mill Street		Salisbury	Wicomico	Md

22a. **I certify** thot I took chorge of the remains described obove, held on Autopsy ☐, Inspection ☐, Inquiry ☒, ond in my opinion death resulted from: Noturol couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Philip A. Insley M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 10-27-1970

EXAMINER'S NAME (Type) Dr. Philip A. Insley M.D. ADDRESS (Street, city, town, or county) 116 East Main St. Salisbury, Maryland, Wicomico

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-29-1970	Whatcoat Cemetery	Snow Hill Worcester, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury, Maryland	OCT 28 1970	Burton D. Rogers

VR A15ME (5) 1DM REV. 1/68

1

15884

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15910

1. DECEASED-NAME (Type or print) First: Walter Middle: W. Last: Price	2a. DATE OF DEATH Month: October Day: 30 Year: 1970	2b. HOUR: 10:04 PM	
3. SEX: Male.	4. RACE: White	5. DATE OF BIRTH: June 6, 1889	6. AGE (In years last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Parole & Probation Officer	12b. KIND OF BUSINESS OR INDUSTRY: State of Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Snow Hill	13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 103 N. Morris St.			
14. FATHER'S NAME First: James Middle: Samuel Last: Price	15. MOTHER'S MAIDEN NAME First: Cordelia Middle: Richardson Last:		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown): Yes (If yes give war or dates of service): W.W.I	16b. SOCIAL SECURITY NO.: 213 24 4395	17. INFORMANT: Wm. H. Price II, Address: ~~Sonn~~ Easton, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

4419

IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 10-30, 1970, to 10-30, 1970, that (I) (we) last saw the deceased alive on 10-30 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Owen R. Hess, M.D. DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-30-70	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11-2-70	23c. NAME OF CEMETERY ~~OR CREMATORY~~: Makemie Presbyterian	23d. LOCATION (City or Town) (County) (State): Snow Hill Md.
24. FUNERAL DIRECTOR: Norman F. Ukemi, ADDRESS: Snow Hill Md.	25a. REC'D BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon R. Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A16 (4) ISM 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15885 15911

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Minnie	Emma	Pusey	October	6	1970	11 05 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	WHITE	Jan 27 1884	86 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	NONE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Wicomico	Salisbury	YES ☑ NO ☐	107 Princeton Ave

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Samuel	Mack	Pusey	Cureleo	Whayland	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Mrs George Call	Salisbury Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4330

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ARTERIOSCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☑	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I ar Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City ar Town	County	State

22a. **I certify** that (I) (~~His hospital~~) attended the deceased from Sept 23, 1970, to Oct 6, 1970, that (I) (~~saw~~) last saw the deceased alive an Oct 6 1970, and that in (my) (~~our~~) apinion death accurred an the date and haur and fram the causes stated abave, (I) (~~was~~) (did) (~~didnot~~) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Thomas C Hill Jr	MD	☑	☐	☐	10-6-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
THOMAS HILL JR.	Pine Bluff Rd, SALISBURY MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Tawn) (Caunty) (State)
BURIAL	10/10/1970	ST ANDREW CEMETERY	PRINCESS ANNE, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
LEVIN R. WILSON	PRINCESS ANNE, MD.	OCT 14 1970	B.T.D. Register

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15886

CERTIFICATE OF DEATH

15912

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month Day Year	2b. HOUR
CLIFFORD	LEE	REDDISH, SR.	October 30 1970	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	June 27, 1915	55 YRS.		

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	108 Prince Street	Electrician	

13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury		108 Prince Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
James	Francis	Reddish	Iva	Pearle	Willis

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife)	Address
Yes	WW II	145-09-8719	Mrs. Louise T. Reddish, Salisbury, Maryland	same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. I **certify** that (I) (this haspital) attended the deceased from 9-72, 19 72, to 10-30, 19 70, that (I) (we) last saw the deceased alive on 10-30 19 70 and that in (my) (aur) opinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. [ ]	MED. DIRECTOR [X]	STAFF PHYS. [ ]	22c. DATE SIGNED
Wilbur R. Ellis					October 31 /1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. Wilbur R. Ellis	Salisbury, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	Nov. 3, 1970	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	NOV 4 1970	Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 haurs after death.

VR A15 (1)
45M - 1/69

1

15897

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Viola G. Ridgell	2a. DATE OF DEATH Month / Day / Year	October 31 1970
2b. HOUR	6:30 M		
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH	November 5,1902	6. AGE (In years last birthday)	67 YRS.
IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Wicomico Md.
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Deer's Head State Hospital
12a. USUAL OCCUPATION (Kind of work done during mast af working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	St. Mary's
13c. CITY OR TOWN	Beachville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	
13e. STREET AND NUMBER			
14. FATHER'S NAME First / Middle / Last	George Green	15. MOTHER'S MAIDEN NAME First / Middle / Last	Emma Yeatman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ar unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Address	Frank Ridgell Sr. Beachville, Maryland		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

7123

IMMEDIATE CAUSE (a) Myocardial Infarction

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) Rheumatoid Arthritis, Severe

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days / Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at wark [ ]	21e. PLACE OF INJURY (AT HOME, EARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street ar R.F.D. No. / City ar Town / County / State	

22a. **I certify** thot (I) (this hospitol) ottended the deceased from October 13 19 70, to October 31 19 70, thot (I) (we) lost sow the deceased alive on October 31 19 70, and thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE	Francis J Murphy Jr MD	DEGREE	ATTENDING PHYS. [ ]	MED. DIRECTOR [X]	STAFF PHYS. [ ]
22c. DATE SIGNED	10/31/70				
22d. PHYSICIAN'S NAME (Type)	Francis J. Murphy , Jr. MD.	22e ADDRESS	Deer's Head State Hospital Salisbury, Maryland		

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	Nov.3,1970	St Michaels Cemetery	Ridge,	St Mary's, Maryland
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley	Leonardtown, Maryland	NOV 6 1970	Vernon O. Randall	

VR A15 (R)
45M - 1/69

1

15888

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 2 and 3) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Mae; Middle: R.; Last: Ringe
2a. DATE OF DEATH: Month: 10; Day: 8; Year: 70
2b. HOUR: 5:30 A M
3. SEX: Female
4. RACE: Caucasian
5. DATE OF BIRTH: 8-14-1882
6. AGE (In years last birthday): 87 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Phila. Pa.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Wicomico Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Never Work
12b. KIND OF BUSINESS OR INDUSTRY: Never
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: Booth St.
14. FATHER'S NAME: First: Louis; Middle; Last: Ringe
15. MOTHER'S MAIDEN NAME: First: Mary; Middle; Last: Ruchman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 236-15-1820
17. INFORMANT: John B. Parson Home Records; Address: Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months / Yrs.
4369
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Parkinsons Syndrome
19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 7/8, 1970 to 10/8, 1970, that (I) (we) last saw the deceased alive on 10/7/1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A.C. Mitchell
DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/8/70
22d. PHYSICIAN'S NAME (Type): A.C. Mitchell, MD
22e. ADDRESS: Fruitland Md - 21826

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-10-1970
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Md.
24. FUNERAL DIRECTOR: Hill Funeral Home
ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: OCT 9 1970
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15889 — 15916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Curtis Middle: FRANKLIN Last: STANLEY
2a. DATE OF DEATH Month: Oct. Day: 10 Year: 1970
2b. HOUR: 10:29 P.M.
3. SEX: MALE
4. RACE: CAU.
5. DATE OF BIRTH: 6/19/08
6. AGE (In years last birthday): 62 YRS. IF UNDER 1 YEAR MONTHS DAYS; IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country): SMYRNA Delaware
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury, Md.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Wicomico Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Oil Burners Rep
12b. KIND OF BUSINESS OR INDUSTRY: Owner
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: 407 Atlantic Ave.
14. FATHER'S NAME First: Benjamin F. Middle: Last: Stanley
15. MOTHER'S MAIDEN NAME First: Edith Middle: Last: Cavanaugh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 212-09-7234
17. INFORMANT: Mrs. Georgia Wilson Address: See Sec 13.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of rectum
DUE TO, OR AS A CONSEQUENCE OF (b): widespread metastasis.
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1541
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 5/20/70, 19___, to 10/10/70, 19___, that (I) (we) last saw the deceased alive on 10/10/70 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: A.C. Mitchell M.D. DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 10/11/70
22d. PHYSICIAN'S NAME (Type): A.C. Mitchell M.D.
22e. ADDRESS: Fruitland, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 10-13-1970
23c. NAME OF CEMETERY OR CREMATORY: Pittsville Cemetery
23d. LOCATION (City or Town) (County) (State): Pittsville Wic. Md.
24. FUNERAL DIRECTOR: Hill Funeral Home ADDRESS: Salisbury, Md.
25a. REC'D BY REGISTRAR DATE: OCT 14 1970
25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

VR A15 (41)
45M - 1X69

15890

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15917

1. DECEASED-NAME (Type or print) First: Norris Middle: Edward Last: TAYLOR	2a. DATE OF DEATH Month: OCTOBER Day: 6 Year: 1970	2b. HOUR: 2:15 PM	
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: Jan. 4, 1918	6. AGE (In years lost birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Worcester	13c. CITY OR TOWN: Ocean City	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER
14. FATHER'S NAME First: John Middle: Last: Taylor	15. MOTHER'S MAIDEN NAME First: Mary Middle: Last: Ross		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service): no	16b. SOCIAL SECURITY NO.: 077-09-3522	17. INFORMANT: Mrs. Joy Bifulco; Address: Huntington Station New York	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebrosis of liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: unknown

5719

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-10, 1970, to 10-6, 1970, that (I) (we) last saw the deceased alive on 10-6 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William R. Ellis	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 10-15-70	
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS		

23a. BURIAL, CREMATION, REMOVAL (Specify): burial	23b. DATE: 10/10/70	23c. NAME OF CEMETERY OR CREMATORY: Perryhawkin	23d. LOCATION (City or Town) (County) (State): Princess Anne; Somerset; Md.
24. FUNERAL DIRECTOR: James Henman	ADDRESS: Princess Anne, Md.	25a. REC'D BY REGISTRAR DATE: OCT 16 1970	25b. REGISTRAR'S SIGNATURE: Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

3 6 1 4

15891

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15918

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
FOREST	CARSON	THOMPSON	10	11	1970	7 A.M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	White	Oct. 1, 1908	62 YRS.				

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Indiana	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Administrator	Hospital

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomio	Salisbury	YES ☒ NO ☐	313 Newton St.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Clay		Thompson	Florence		Eubank

16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes 6-2-1932 8-1-1964	224-52-3233	Mrs. Ethel T. Thompson, See Sec 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 yrs.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20o. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22o. I **certify** that (I) (this hospital) attended the deceased from 10 [illegible], 19 69 to 10, 19 70 that (I) (we) last saw the deceased alive on Oct. 11 1970, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
David J. Gilmore MD				10-12-1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DAVID J. GILMORE	SALISBURY, MARYLAND

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-14-1970	Arlington Nat. Cemetery	Arlington, Va.

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury, Maryland	OCT 14 1970	[signature]

VR A15 (4)
45M - 1/69

1

Item #16b & Item #5, Film G430 10/30/70 km

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15892 — 15919

1. DECEASED NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
KATHRYN	MARY	THOMPSON	10	23	1970	5 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Female	White	10-6-1979 1900	70 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Pa.	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Salisbury Nursing Home	House Wife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	207 Glen Ave.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Alfred		Tunnell	Katie		Harrison

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	———	218-20-4974	Mr. Henry D. Thompson	see sec 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma Colon with
DUE TO, OR AS A CONSEQUENCE OF (b) widespread metastasis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1538
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 9/28, 19 70, to 10/23, 19 70, that (I) (we) last saw the deceased alive on 10/23 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
[signature]	M.D.	☒	☐	☐	10-23-1970

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. E.M. BEARDSLEY	Civic Ave., Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-25-1970	Spring Hill Memory Gardens	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hill Funeral Home Salisbury, Maryland	OCT 26 1970	Bettie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-14
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15893

CERTIFICATE OF DEATH

15920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARGIE	Middle: VIRGINIA	Last: TINGLE	2a. DATE OF DEATH: Month: October; Day: 22; Year: 1970	2b. HOUR: 10:45 AM
3. SEX: FEMALE	4. RACE: White	5. DATE OF BIRTH: December 10, 1923	6. AGE (In years last birthday): 46 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico		Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Vacinating chickens	12b. KIND OF BUSINESS OR INDUSTRY: Feed Co.		
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 1007 Cecil Street	
14. FATHER'S NAME First: George	Middle: Dewey	Last: Brittingham	15. MOTHER'S MAIDEN NAME First: Sallie	Middle: Elizabeth	Last: Massey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Son)	R.D. 1 Address Parsonsburg, Md.		
		Mr. Paul J. Tingle, Jr., Parsonsburg, Md.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Liver failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9/30-10/22

5710

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Alcoholic hepatitis — 10yrs

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospital) attended the deceased from 9/30, 1970, to 10/22, 1970, that (I) (we) last saw the deceased alive on 10/22 1970, and that in (my) (our) apinion death accurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Alberta Polin MD	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: 10/22/70
22d. PHYSICIAN'S NAME (Type): Alberta Polin, M.D.	22e. ADDRESS: Salisbury, Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct. 27, 1970	23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Maryland	
24. FUNERAL DIRECTOR: HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	ADDRESS	25a. RECD BY REGISTRAR DATE: OCT 28 1970	25b. REGISTRAR'S SIGNATURE: Bertie D. Rogers	

VR A-15 (4) ASM 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15894

CERTIFICATE OF DEATH

15921

1. DECEASED-NAME (Type or print) First	Middle	Last	2o. DATE OF DEATH Month	Day	Year	2b. HOUR
Inez	Coster	Ussery	10	8	70	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	June 24,1927	43 YRS.				

7o. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Md.	USA		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula Gen. Hosp.	at home	at home

13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Baltimore	Baltimore	YES [X] NO [ ]	2109 Lake Montebello Terrace

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Earl		Coster	Eunice		Gardner

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		Earl B. Coster	Same as 13

MEDICAL CERTIFICATION

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Necrotizing Hemorrhagic Pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 days
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5770

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19o. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 10-6, 1970, to 10-8, 1970, that (I) (we) last saw the deceased alive on 10-8 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
H. A. Briele		[X]	[ ]	[ ]	10-9-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Henry A. Briele, M.D.	Medical Center, Salisbury, Md.

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10-10-70	Loudon Park Cemetery	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John Ullrich, Rt. 50, Berlin, Md.	OCT 13 1970	Bessie D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4-68)
45M - 1X

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE HEALTH DEPT.

15895

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15922

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED	Month Day Year	2b. HOUR
ROBERT	BLACK	WALLACE	☒ ☐	10-22-70	7:45 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	August 13, 1918	52 YRS.			October 22 19 70	8:40 A M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		WICOMICO Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Waterman - Seaman	Boat Co.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Wicomico	Salisbury	YES ☒ NO ☐	309 Hammond Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Norman	Irving	Wallace	Bessie	Pauline	Daniels

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife) ADDRESS
Yes	Army WWII	212-16-1946	Mrs. Evelyn D. Wallace, Salisbury, Maryland same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fractured skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: sudden
8190
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
	7:45 A.M. 10-22-70	Driver of auto involved in accident.

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	highway	Route 13, nr. Fruitland, Wico, Md.

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Earl L. Royer M.D.
EXAMINER'S NAME (Type) Earl L. Royer, M. D.
ADDRESS (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED October 23/1970

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 24, 1970	Parsons Cemetery	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 27 1970	Bertie D. Rogers

VR A15ME (5) 8M-1/70

Item #23a Film #GL30
11/19/70 pcs

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15896

CERTIFICATE OF DEATH

15923

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Mildred	Geraline	WEBSTER	October 30 1970	7 a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	negro	April 24, 1930	40 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	School Teacher	

13a. USUAL RESIDENCE (Where deceased lived, before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	Wic.	Salisbury		Rt 2 West Rd.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Rayfield		Winder	Nettie		Dennis

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no.	----	215-26-7221	John Webster	Rt 2 West Rd. Salisbury

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Extensive Metastasis Abd & Chest.
DUE TO, OR AS A CONSEQUENCE OF
(c) Ovarian Adenocarcinoma

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
July 1470	Ovarian Carcin.		

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 9-30-, 1970, to 10-30, 1970, that (I) (we) last saw the deceased alive on 10-29 1970, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Robert Lee Baker MD		☒	☐	☐	10/30/70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Robert Lee Baker	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	Nov 2, 1970	Green Acres Mem Park	Salisbury, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Samuel Savage	New Church, Va.	NOV 4 1970	Vernon G. Randall

VR A15 (4)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15897 — 15924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Willie	Middle:	Last: Weedon	2a. DATE OF DEATH: October 29, 1970 (Month, Day, Year)
2b. HOUR: 10:30 P M			
3. SEX: Male	4. RACE: Negro	5. DATE OF BIRTH: Oct 20-25	6. AGE (In years last birthday): 45 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Kentucky	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Labor	12b. KIND OF BUSINESS OR INDUSTRY: none
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Rhodesdale	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Rural			
14. FATHER'S NAME First: Isaac	Middle:	Last: Weedon	15. MOTHER'S MAIDEN NAME First: Victoria	Middle: White	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Unk (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: (Family)	Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of the tonsil with metastasis to
DUE TO, OR AS A CONSEQUENCE OF: regional lymph glands.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: about 6 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Status post-operative gastrostomy.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that ~~I~~ (this hospital) attended the deceased from Oct. 26, 1970, to Oct. 29, 1970, that ~~I~~ (we) last saw the deceased alive on Oct. 29 1970, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: C. H. Winnacott, M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 10/30/70	
22d. PHYSICIAN'S NAME (Type): C. H. Winnacott, M. D.	22e. ADDRESS: Deer's Head State Hospital, Salisbury Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 11-5-71	23c. NAME OF CEMETERY OR CREMATORY: Parkin Ark Cem	23d. LOCATION (City or Town) (County) (State): Parkin Ark
24. FUNERAL DIRECTOR: Booker & West	ADDRESS: Salisbury	25a. RECD BY REGISTRAR DATE: NOV 4 1970	25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

VR A15 (4)
45M - 1/69

1

15898

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

15925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: GRANVILLE Middle: C. Last: WILKINS	2a. DATE OF DEATH Month: OCTOBER Day: 10 Year: 1970	2b. HOUR: 6 15 A M	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 19, 1890	6. AGE (In years last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Wicomico Md.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Peninsula General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): GROCERY CLERK	12b. KIND OF BUSINESS OR INDUSTRY: STORE GROCERY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: WILLARDS	13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: X X
14. FATHER'S NAME First: JAMES Middle: Last: WILKINS	15. MOTHER'S MAIDEN NAME First: LAURA Middle: Last: TRUITT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): X (If yes give war or dates of service): X	16b. SOCIAL SECURITY NO.: 212-03-3618	17. INFORMANT: Mrs William J. Dennis — Address: Willards Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hours.
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Arteriosclerosis. — Not Known.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebral Arteriosclerosis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 10 10 19 70, to 10 10 19 70, that (I) (~~we~~) last saw the deceased alive on 10 10 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐		22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 10-13-70	23c. NAME OF CEMETERY OR CREMATORY: WILLARDS	23d. LOCATION (City or Town): WILLARDS (County): WICOMICO (State): Md.	
24. FUNERAL DIRECTOR: Fuller Whaley	ADDRESS: Salisbury, Md.	25a. REC'D BY REGISTRAR DATE: OCT 13 1970	25b. REGISTRAR'S SIGNATURE: Burrid D. Rogers	

VR A15 (4)
45M - 1X69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15899 — 15926

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year
LUMSDEN	HOLT	WILSON	10 - 16 - 70

2b. HOUR: 6.40 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	April 22, 1912	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] C	Wicomico Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Salisbury	Peninsula General Hospital	Service Station Operator	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Delaware	Sussex	Delmar	YES [ ] NO [ ]	701 Grove Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Harry	Layfield	Wilson	Katherine		Holt

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT (Wife)	Address
Yes	WW II		Mrs. Elizabeth M. Wilson, Delmar, Delaware	same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

1621
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-12, 1970, to 10-16, 1970, that (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Nevins W. Todd		[X]	[ ]	[ ]	10-16-70

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Nevins W. TODD M.D.	Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 19, 1970	Hart Cemetery	(Elkneck) North East, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HOLLOWAY FUNERAL HOME, SALISBURY, MARYLAND	OCT 20 1970	

VR A15 (rev.)
45M - 1X68